

State Innovation Model







Driver Diagram

The Iowa SIM Vision: Transforming Health Care to Improve the Health of Iowans

/ Improve Population Heat	h Transform Healthcare	Promote Sustainability
Focus: Diabetes, Obesity, Tobuse, OB ,HAI, Med Safety, SDI		 Focus: Providers participating in value-based purchasing and Financial Impacts to healthcare system/lowans
Goals: by 2018	Primary Driver	Secondary Drivers
Improve the health of lowans in three areas:	Disa to Lorenzo	Assess local and state environment to idea population health needs
Tobacco: Increase quit attempt rate by 2.8%	Plan to Improve Population Health	Develop and deploy interventions, include statewide strategies
Obesity: Decrease prevalence rate by 0.9%		Establish and monitor key population met
Diabetes: Increase AIC rate by 2.3%	Care Coordination	Execute Integrined community kined strategies
Reduce the rate of preventable readmissions by 20% in the Medicaid and Wellmark population		Inform providers for heater care coordinate
		Execute care consideration models
Reduce the rate of preventable ED visits by 20% in the Medicaid and Wellmark population	Community-Based Performance Improvement	Optimize the officers (information (cite (in)))
		Engage Lea dership & receive leadership Commitment
		Develop & implement quality improvement strategies
Increase participation in Value Based Purchasing in Iowa, by evidence of 50% of Medicaid, Wellmark, and Medicare payments linked to VBP contracts	Value Based Purchasing (VBP)	Conquit_rapid cycle evaluation of perform data to stakeholders
		Align payers invalue reimbursement and Quality strategies
		Implement VBP into the new Monaged Ca system in Medicaid



Categorization of Population Health Activities

Bucket #1: Traditional Clinical Approaches Bucket #2: Innovative Patient-Centered Care

Bucket #3: Community -Wide Health







Source: John Auerbach, CDC







Statewide Strategy Plans: Population-based, Community Applied Interventions

- Tobacco
- Diabetes
- Healthcare Associated Infections
- Medication Safety
- Nutrition and Physical Activity/Obesity
- Obstetrics
- In development: Social Determinants of Health,
 Care Coordination

Iowa Healthcare Collaborative

http://idph.iowa.gov/SIM





Driver Diagram

The Iowa SIM Vision: Transforming Health Care to Improve the Health of Iowans

Improve Population Health		Transform Healthcare	Promote Sustainability
	tes, Obesity, Tobacco Med Safety, SDH	Focus: Preventable Utilization (ED visits and Inpatient admissions)	 Focus: Providers participating in value-based purchasing and Financial Impacts to healthcare system/Iowans
Goals: by	2018	Primary Driver	Secondary Drivers
Improve the health of lowans in three areas:		Plan to Improve	Assess local and state environment to I dem population health needs
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Community Care Coalition (C3) Initiative

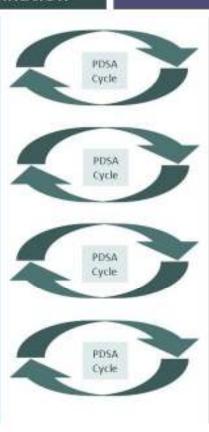
Community Care Coalitions:

Consist of a broad group of community partners including health, human services, education, aging, city planners, residents, among others. Are guided by a Steering Committee consisting of a small group consisting of hospitals, health providers, public health, human service organizations, etc. Build and participate in referral processes, participate in process improvement, promote C3 interventions, and educate on the benefits of community-based strategies to support healthy behaviors.

Community Care Coordination

Implementing Interventions from SIM Statewide Strategy Plans

Social Determinants of Health
Referrals will be received, barriers identified, and
referrals to resources may be provided



DIABETES

Community-identified interventions from SIM Diabetes Statewide Strategy Plan and/or local CHNA & HIP

TOBACCO

Community-identified interventions from SIM Tobacco Statewide Strategy Plan and/or local CHNA & HIP

OBESITY

Community-identified interventions from SIM Obesity Statewide Strategy Plan and/or local CHNA & HIP

CHNA & HIP PRIORITY AREA
Community-identified interventions
from local CHNA & HIP and could include obstetrics, healthcare-associated
infections, etc.

Population-based,
Community-applied
policy, systems, and
environmental change
initiatives included in
statewide strategy plans
to support healthy
behaviors and promote
sustainability for longterm change.

Social Determinants of Health

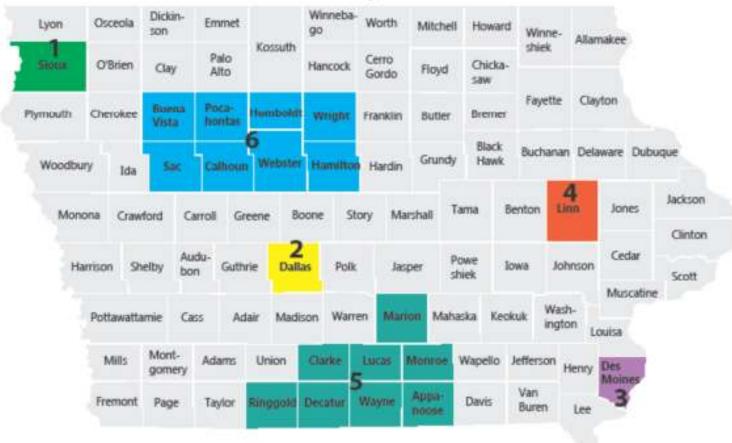
<u>Definition:</u> Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Economic Stability
- Education
- Health and Healthcare
- Neighborhood and Built Environment
- Social and Community Context

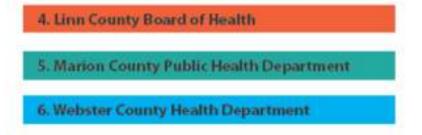
Source: Healthy People 2020



State Innovation Model Community Care Coalition Initiative Grantees







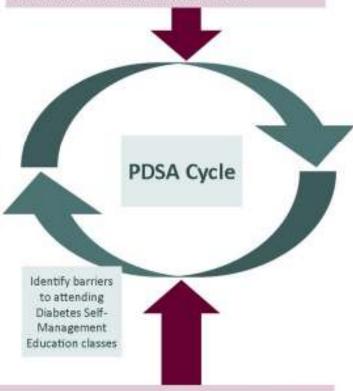
Community Care Coalition (C3) Diabetes Example

Example of a community-selected intervention from the SIM Diabetes Statewide Strategy Plan

Community Care Coordination

Social Determinants of Health

Referrals will be made; barriers identified and may include lack of access to prescriptions or healthy foods; and resources and referrals may be provided Implement process changes based on data analysis. For example, modifications could be made to a referral system to diabetes self-management education program, and/or change the location of the diabetes self-management education course to a community location more accessible to families of low income.



Data will continually be collected by C3 applicant, coalition partners, and IHC to implement community-based performance improvement strategies. Data may include:

- # of referrals
- referral sources
- SWAN data

- · Pharmacy data
- NOF measures to include HgbA1C
- # VIS data

Implementing Interventions from SIM Statewide Strategy Plans

DIABETES

Community-Identified interventions from SIM Diabetes Statewide Strategy Plan

Incorporate standardized glucose testing at annual physical appointments.

Identify barriers within primary care offices to address diabetes screening with patients.

Equip providers to recognize and address social determinants of health. Encourage patient and provider discussions to identify social determinants of health and patient needs impacting care.

Incorporate referrals to community-based services to assist in addressing barriers to care.

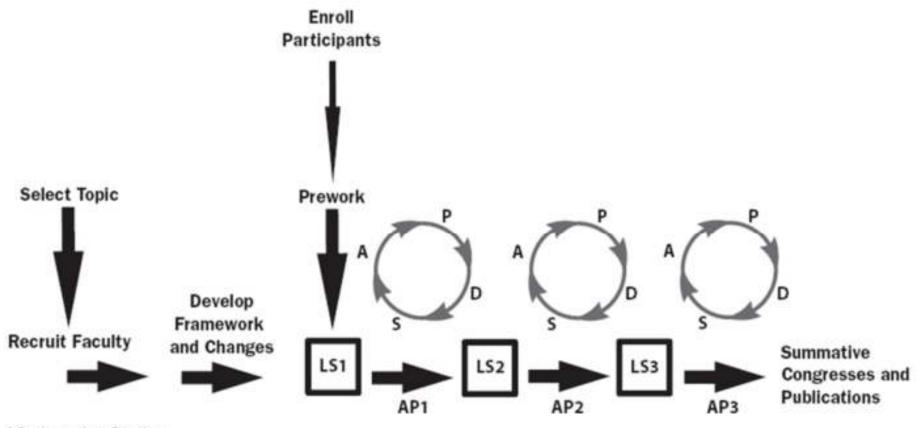
Educate providers and consumers about the purpose and locations of diabetes self-management education and training offerings. Increase provider referral of diagnosed patients to diabetes selfmanagement education and training.

Population-based, Community-applied policy, systems, and environmental change initiatives included in statewide strategy plans to support healthy behaviors and promote sustainability for long-term change. Leverage the work of other concurrent efforts (Healthiest State Initiative, Healthy lowans plan, Wellmark Blue Zones, etc.) to support local access to healthy foods and built environments to promote active lifestyles.

Specific examples include improving access to healthy foods at food pantries and food banks, educate on benefits of walkable communities, embed permanent payment structure for diabetes self-management education.



Figure 2. Breakthrough Series Model



LS1: Learning Session AP: Action Period P-D-S-A: Plan-Do-Study-Act

Supports:

Email • Visits • Phone Conferences • Monthy Team Reports • Assessments









Questions?

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